Coastal Fertility Medical Center | RSMC Irvine
Medical Director: Lawrence B. Werlin M.D.

15500 Sand Canyon Ave. Suite 100
Irvine, CA 92618
Tel: 949.726.0600
Fax: 949.726.0601
Email: info@coastalfertility.com
Web: www.coastalfertility.com

Patient Infertility History Questionnaire

(Important: Please complete and return 5-7 Business days prior to your appointment)

PART I: CONTACT INFORMATION - Primary Patient (Female)

First Name _____ **Middle Initial** ____ **Last Name** _____ Age:

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____
Home Street Address _____
City _____ State_____ Zip/Postal Code_____ Country _____
Indicate which number to call or leave messages;

[ ] Home_____ [ ] Work_____ [ ] Cell_____

Email Address:_____

Are you married? [ ] Yes [ ] No [ ] Divorced [ ] Other _____

Spouse/Partner: [ ] Not Applicable

First Name _____ **Middle Initial** ___ **Last Name** _____ Age:

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____
Home Street Address _____
City _____ State_____ Zip/Postal Code_____ Country _____
Indicate which number to call or leave messages:

[ ] Home_____ [ ] Work_____ [ ] Cell_____

Email Address:_____

By whom were you referred?
[ ] Physician
Name _____ Phone ( ) _____

Address _____

[ ] Former Patient/Friend/Relative _____
[ ] Web Site _____
[ ] Insurance (Name of Insurance)_____

Who is your Ob/Gyn?
Name _____ Phone ( ) _____

Address _____

Who is your Primary Care Physician?
Name _____ Phone ( ) _____

Address _____

Name_____ DOB _____

Physician Notes
(for office use only)

PART II: FEMALE MEDICAL HISTORY AND INFORMATION (Primary Patient)

Reason for Visit: [ ] Infertility Evaluation [ ] Sperm Insemination[ ] Other _____

What are your expectations for this visit?_____

Any questions you wish to address:_____
_____

Do you have any personal, ethical, or relations objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? [ ] No [ ]Yes_____

How many months have you been having intercourse without using any form of birth control?_____

Pregnancy History

* Number of ALL Pregnancies:_____
* Number of Miscarriages (less than 20 weeks): _____
* Number of Ectopic / Tubal Pregnancies _____
* Number of Elective Terminations (Abortions):_____
* Number of Full Term Deliveries: _____ Of these, how many were live births?____ How many were stillborn?_____
* Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? _____
* Any Pregnancies with Birth Defects? [ ] No [ ] Yes - explain_____

Date Pregnancy Ended or delivered	Months to Conception	Treatments to Conceive	Deliver Type/D&C Complications	Current Partner?
1.				[ ] Y [ ] N
2.				[ ] Y [ ] N
3.				[ ] Y [ ] N
4.				[ ] Y [ ] N
5.				[ ] Y [ ] N
6.				[ ] Y [ ] N

Menstrual Cycle History

* Menstrual cycle pattern (check all that apply): [ ] Regular periods [ ] Irregular periods [ ] Spotting before periods [ ] No periods
  [ ] Heavy periods [ ] Light periods [ ] Bleeding between periods

* Number of days between the start of one period to the start of the next period: _____days
* How many days of bleeding do you have? _____ days
* Dates of the 1st day of your last 2 menstrual periods: _____/ _____/ _____: _____/ _____/_____
* Age when you had your first period: _____ years old
* Age when you first noticed: Breast development:_____years old Pubic hair:_____years old Underarm hair:_____years old
* How many periods do you have per year?_____
* Do you need medication to bring on a period? [ ] Yes - what type?_____ [ ] No
* If you do not have periods, at what age did you stop having them?_____ years old
* Do you have server cramping or pelvic pain with your periods? [ ] Yes:__Always __ Sometimes __ Recently __In the past [ ] No

Contraceptive Methods (History)

[ ] None [ ] Condoms - dates of use _____ [ ] Diaphragm - dates of use _____ [ ] IUD -Dates of use _____
[ ] Birth control pills - dates of use _____ - complications?_____ [ ] Never used birth control pills
[ ] Inject able contraception (Depo-Provera, Lunelle (TM), etc.) - dates of use _____- Complications? _____
[ ] Skin patch - dates of use _____- complications? _____ [} Foam or Jelly
[ ] Tubal sterilization procedure (tubes tied) - date (month/year) _____/_____ [ ] Tubes untied - date (month/year) _____/_____
*Did your mother take DES when she was pregnant with you? [ ] Yes [ ] No [ ] Don't know

Sexual History

* How many times do you have intercourse per week? ____times per week [ ] None [ ] Not applicable
* Have you used over-the-counter ovulation kits to time intercourse [ ] Yes [ ] No
* Do you have pain with intercourse? [ ] Yes [ ] No
* Do you use lubricants (K-Y Jelly*, etc.) during intercourse? [ ] Yes - what types? _____ [ ] No

Have you had any of the following sexually transmitted diseases or pelvic infections? [ ] Yes (check all that apply) [ ] No

[ ] Chlamydia - date	[ ] Gonorrhea - date	[ ] Herpes - date	[ ] Genital warts/HPV - date
[ ] Syphilis - date	[ ] HIV/AIDS - date	[ ] Hepatitis - date	[ ] Other

Name_____ DOB _____

Pap Smear Medical History

* When was your last pap smear (month end year) ? _____/_____ [ ] Normal [ ] Abnormal
* When was your last abnormal pap smear? _____/_____ [ ] Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

[ ]Yes (check all that apply) [ ] No

[ ] Colposcopy [ ]Cryosurgery (Freezing) [ ]Laser treatment [ ]Conization [ ]LEEP procedure

Breast Screening History

Have you ever had a mammogram? [ ] No [ ] Yes - date_____ Result: [ ] normal [ ] abnormal - explain _____

Do you perform self breast exams? [ ] Yes [ ] No

Medical History **Social History**

* Are you allergic to any medications? [ ]No [ ]Yes (Please list and describe reactions) _____

_____

_____

* Are you allergic to any foods (peanuts, eggs, etc.)? [ ]No [ ]Yes (Please list and describe reactions) _____

_____

* List any medications you are currently taking, including over the counter medicines . _____

_____

* Do you take any herbal medicines/vitamins or health food store supplements? [ ] No [ ]Yes (Please list) _____

* Do you have any medical problem(s)? [ ]No [ ]Yes (Please list type, dates, and treatments.)

(1)_____

(2)_____

(3)_____

(4)_____

(5)_____

* Did you have either of these childhood illnesses? [ ]Chickenpox (Varicella) [ ]German Measles (Rubella) [ ]Don't know

Other childhood diseases:_____

Vaccinations

* How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ [ ] None

* Chickenpox (Varicella): [ ] No [ ] Yes (dates_____) [ ] Don't know
* MMR - Measles, Mumps, and Rubella (German Measles): [ ] No [ ] Yes (dates_____) [ ] Don't know
* BCG (Tuberculosis): [ ] No [ ] Yes (dates_____) [ ] Don't know
* Hepatitis B: [ ] No [ ] Yes (dates_____) [ ] Don't know
* Polio: [ ] No [ ] Yes (dates_____) [ ] Don't know
* Influenza: [ ] No [ ] Yes (dates_____) [ ]Don't know

* Do you smoke cigarettes? [ ] No [ ] Yes How many/day? ____ How many years? ____ [ ] Quit - when?
* Do you drink alcohol? [ ] No [ ] Yes

[ ] Beer - # per week ____ [ ] Wine - # per week ____ [ ] Liquor - # per week _____

* Do you use marijuana, cocaine, or any other similar drug? [ ] No [ ] Yes (describe_____)
* Do you exercise? [ ] No [ ] Yes (describe_____)
* Are you aware of any radiation exposures other than X-rays? [ ] No [ ] Yes (describe_____)

Physician Notes (for office use only)_____

_____

_____

Name_____ DOB _____

Surgical History

Have you had any surgeries [ ] No [ ] Yes (List all surgeries in chronologic order)

Year	Reason and Type of Surgery
_____	(1) _____
_____	(2) _____
_____	(3) _____
_____	(4) _____
_____	(5) _____
_____	(6) _____
_____	(7) _____

*Did you have any anesthesia problems? [ ] No [ ] Yes (describe) _____

Physical Symptoms

General
[ ] Diabetes [ ] Hair loss
[ ] Anorexia/Bulimia
[ ] Lack of energy
[ ] Fever/chills
[ ] Other _____
_____
[ ] None

Endocrine/Hormonal:
[ ] Recent weight gain or loss
[ ] Thyroid gland problems
[ ] Rapid weight gain or loss
[ ] Excessive hunger/thirst
[ ] Temperature intolerance- hot flashes or feeling cold
[ ] Other _____
[ ] None

Gastrointestinal
[ ] Nausea/Vomiting [ ] Ulcers
[ ] Hepatitis [ ] Diarrhea
[ ] Blood in your stools
[ ] Irritable Bowel Syndrome
[ ] Change in bowel habits
[ ] Colitis (ulcerative or Cohn's)
[ ] Other _____
[ ] None

Musculoskeletal:
[ ] Unusual muscle weakness
[ ] Decreased energy/stamina
[ ] Rheumatoid arthritis
[ ] Lupus Erythematosus
[ ] Myasthenia gravis
[ ] Other _____
[ ] None

Mental Health Problems:
[ ] Depression [ ] Anxiety disorder
[ ] Schizophrenia
[ ] Other
[ ] None

Head, Eyes, Ears, Nose, and Throat
[ ] Dizziness [ ] Loss of sense of smell
[ ] Headaches [ ] Chronic nasal congestion
[ ] Blurred vision [ ] Ringing ears
[ ] Hearing loss/deafness
[ ] Other _____
[ ] None

Breasts:
[ ] Discharge (Clear? _____Bloody? ____ Milky?____)
[ ] Lumps [ ] Pain [ ]Cancer
[ ] Abnormal mammogram
[ ] Reduction
[ ] Augmentation/Breast Implants (saline? _____ silicone? _____)
[ ] Other _____
[ ] None

Genito-Urinary:
[ ] Bladder infections
[ ] Kidney infections
[ ] Vaginal infections
[ ] Frequent urination [ ]Leaking Urine
[ ] Blood in the urine
[ ] Herpes
[ ] Other _____
[ ] None

Hematologic:
[ ] Blood clotting disorder/Blood clot
[ ] Sickle Cell Anemia [ ] Thrombophlebitis
[ ] Easy bruising
[ ] Swollen glands/lymph nodes
[ ] Blood transfusions (dates/reasons_____)
[ ] Other _____
[ ] None

Respiratory
[ ] Shortness of breath
[ ] Asthma [ ] Bronchitis
[ ] Pneumonia [ ]Tuberculosis
[ ] Bloody cough
[ ] Other
[ ] None

Neurological Problems:
[ ] Weakness/Loss of balance
[ ] Seizures/Epilepsy
[ ] Headaches
[ ] Migraine headaches
[ ] Numbness
[ ] Memory Loss
[ ] Other _____]
[ ] None

Skin/Extremities:
[ ] Unexplained rash/inflammation
[ ] Acne
[ ] Skin caner
[ ] Burn injury
[ ] Moles changing in appearance
[ ] Excess hair growth
[ ] Other _____
[ ] None

Cardiovascular:
[ ] Palpitations/Skipped beats
[ ] Chest pain [ ] Heart attack
[ ] Stroke [ ] Murmurs
[ ] High blood pressure
[ ] Rheumatic fever
[ ] Mitral valve prolapse (need antibiotics before dental procedures? [ ] Yes [ ] No
[ ] Other _____
[ ] None

Physician Notes (for _____
_____
_____
_____

Name_____ DOB _____

Family History

	Living	Cause of Death/Age at Death
* Mother	[ ] Yes - age [ ] No	_____
* Father	[ ] Yes - age [ ] No	_____
* Brother (s)	[ ] Yes - age [ ] No	_____
	[ ] Yes - age [ ] No	_____
	[ ] Yes - age [ ] No	_____
* Sister (s)	[ ] Yes - age [ ] No	_____
	[ ] Yes - age [ ] No	_____
* Maternal Grandmother	[ ] Yes - age [ ] No	_____
* Maternal Grandfather	[ ] Yes - age [ ] No	_____
* Paternal Grandmother	[ ] Yes - age [ ] No	_____
* Paternal Grandfather	[ ] Yes - age [ ] No	_____

What is your Ancestry?

[ ] African - American
[ ]Amer.Indian/NativeAmer.
[ ] Ashkenazi Jewish
[ ] Asian-American
[ ] Cajun/French Canadian
[ ] Caucasian
[ ] Eastern European
[ ] Hispanic - American
[ ] Northern European
[ ] Southern European
[ ] Other- (specify)

Would you like to be screened for :

[ ] Cystic Fibrosis: ___Yes ___No
[ ] Sickle Cell Anemia: ___Yes___No
[ ] Tay-Sachs Disease ___Yes ___No
[ ] Thalasemia: ___Yes ___No

Disorders in Your Family

Relationship to You

* Breast cancer	[ ] Yes _____	[ ] No	[ ] Don't Know
* Ovarian cancer	[ ] Yes _____	[ ] No	[ ] Don't Know
* Ovarian cancer	[ ] Yes _____	[ ] No	[ ] Don't Know
* Other cancer_____	[ ] Yes _____	[ ] No	[ ] Don't Know
* Diabetes	[ ] Yes _____	[ ] No	[ ] Don't Know
*Thyroid Problems	[ ] Yes _____	[ ] No	[ ] Don't Know
* Heart Disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Blood Clots	[ ] Yes _____	[ ] No	[ ] Don't Know
* Obesity	[ ] Yes _____	[ ] No	[ ] Don't Know
* Psychiatric problems	[ ] Yes _____	[ ] No	[ ] Don't Know
* Tuberculosis	[ ] Yes _____	[ ] No	[ ] Don't Know
* Endometriosis	[ ] Yes _____	[ ] No	[ ] Don't Know
* Infertility	[ ] Yes _____	[ ] No	[ ] Don't Know
* Menopause before age 40	[ ] Yes _____	[ ] No	[ ] Don't Know
* Birth Defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Cystic Fibrosis	[ ] Yes _____	[ ] No	[ ] Don't Know
* Tay-Sachs disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Canavan disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Bloom Syndrome	[ ] Yes _____	[ ] No	[ ] Don't Know
* Gaucher disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neimann-Pick disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Fanconi Anemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Familiar Dysautonia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Muscular Dystrophy	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neurologic brain/spine	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neural Tube Defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Bone/Skeletal Defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Dwarfism	[ ] Yes _____	[ ] No	[ ] Don't Know
* Developmental Delay	[ ] Yes _____	[ ] No	[ ] Don't Know
* Learning problems	[ ] Yes _____	[ ] No	[ ] Don't Know
* Polycystic kidney disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Marfan syndrome	[ ] Yes _____	[ ] No	[ ] Don't Know
* Hemophilia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Sickle Cell anemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Thalassemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Galactosemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Deafness/Blindness	[ ] Yes _____	[ ] No	[ ] Don't Know
* Color/Blindness	[ ] Yes _____	[ ] No	[ ] Don't Know
* Hemochromatosis	[ ] Yes _____	[ ] No	[ ] Don't Know
* None of the above	[ ] Other (specify)_____		

PRIOR INFERTILITY TESTING AND TREATMENT

* Have you had prior infertility testing or treatment elsewhere? [ ] Yes [ ] No

Prior Tests (check all that apply): [ ] Basal body temperature chart (date_____/results_____)
[ ] Thyroid test (date____/results _____) [ ] Ovulation test (date____/results_____)
[ ] Day 3 blood test for FSH level (date____/results _____) [ ] Hysterosalpingogram (HSG) (date____/results_____)
[ ] Laparoscopy (date____/results _____) [ ] Hysteroscopy surgery (date____/results_____)
[ ] Progesterone blood test (date____/results _____) [ ] Prolactin blood test kit (date____/results_____)

Prior Treatment (Check all that apply):

	# of cycles	Dates (mo/year) (mo/year) From ___/___ to___/___	Outcome
[ ] Intrauterine insemination:	_____		__Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant
[ ] Clomiphene citrate with timed intercourse Maximum # tablets per day? _____	____	**From ___/___ to___/___**	__Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant
[ ] Clomiphene citrate with insemination Maximum # tablets per day? _____	_____	**From ___/___ to___/___**	__Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant
[ ] Daily fertility drug injections with insemination: Maximum # vials per day? _____	_____	**From ___/___ to___/___**	__Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant
[ ] Completed in vitro fertilization cycle(s): 1. # eggs___ #embryos transferred ___ #frozen___ 2. # eggs___ #embryos transferred ___ #frozen___ 3. # eggs___ #embryos transferred ___ #frozen___ 4. # eggs___ #embryos transferred ___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant __Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant __Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant __Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant
[ ] Frozen embryo transfers): 1. # eggs___ #embryos transferred ___ #frozen___ 2. # eggs___ #embryos transferred ___ #frozen___ 3. # eggs___ #embryos transferred ___ #frozen___ 4. # eggs___ #embryos transferred ___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant __Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant __Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant __Pregnant: __delivered --Ectopic __Miscarriage __Not Pregnant
Canceled in vitro fertilization attempts (s)	____		
[ ] Any other prior treatment (describe) _____			

* Additional Information/Complications:_____

_____

_____

_____

_____

EMOTIONAL STATUS

* On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. _____
* Do you see a counselor? [ ] No [ ] Yes - for how long _____ How often?_____
* List any anti-depressant/anti - anxiety medications you are currently taking?_____
* Describe any emotional, marital, or sexual problems caused by your infertility._____

_____

_____

_____

PATIENT'S SIGNATURE_____**DATE**_____

_____

I confirm that I have reviewed the information above:
PHYSICIAN'S
SIGNATURE_____**DATE**_____

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable

* Have you been evaluated by a urologist? [ ] Yes [ ] No
* Have you previously conceived with another woman? [ ] Yes: How many times?_____ No: Birth control used? Yes___ No___
* Have you had a semen analysis? [ ] Yes [ ] No
* Do you have difficulty with erections? [ ] Yes [ ] No
* Do you have retrograde ejaculation of sperm into the bladder? [ ] Yes [ ] No
* Have you had any of the following sexually transmitted diseases or pelvic infections?
  [ ] Yes (check all that apply) [ ] No

[ ] Chlamydia - date_____	[ ] Gonorrhea - date_____	[ ] Herpes - date_____	[ ] Genital warts/HPV - date_____
[ ] Syphilis - date _____	[ ] HIV/AIDS - date_____	[ ] Hepatitis - date_____	[ ] Other_____

* Have you had a history of undescended testicles? [ ] Yes - One side___ Both___ [ ] No
* Do you have scrotal or testicular pain? [ ] Yes [ ] No
* Did you have the mumps after puberty? [ ] Yes [ ] No
* Have you had prior injury to your testicles requiring hospitalization? [ ] Yes [ ] No

* Have you been diagnosed with any of the following diseases?
  [ ] Diabetes Mellitus - Yes___ No___ [ ] Cancer - Yes___ No___
  [ ] Multiple Sclerosis - Yes___ No___ [ ] Other neurologic problems - Yes___ No___
  [ ] Prostatic infections - Yes___ No___ [ ] Urinary infections - Yes___ No___
  [ ] High Blood Pressure - Yes___ No___ If yes, any medications?_____

* Have you had any fever in the last 3 months? [ ] Yes [ ] No
* Have you had a vasectomy? [ ] Yes (date_____) [ ] No If yes, have you had a vasectomy reversal? [ ] Yes (date_____) [ ] No
* Have you had surgery for varicocele repair? [ ] Yes [ ] No
* Have you had hernia surgery? [ ] Yes [ ] No
* Did you undergo any bladder or penis surgery as a child? [ ] Yes [ ] No
* Are you exposed to prolonged heat in the workplace? [ ] Yes [ ] No
* Are you exposed to any radiation or harmful chemicals in the workplace? [ ] Yes [ ] No
* Have you had chemotherapy for cancer? [ ] Yes [ ] No
* Are you allergic to any medications? [ ] No [ ] Yes (Please list and describe reactions) _____

List your current medications: _____
_____
List any current medical problem(s):_____
_____
_____

* How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ [ ] None
* Do you smoke cigarettes? [ ] No [ ] Yes How many/day? ____ How many years? ____ [ ] Quit - when?
* Do you drink alcohol? [ ] No [ ] Yes
  [ ] Beer - # per week ____ [ ] Wine - # per week ____ [ ] Liquor - # per week _____
* Do you use marijuana, cocaine, or any other similar drug? [ ] No [ ] Yes (describe_____)
* Do you exercise? [ ] No [ ] Yes (describe_____)
* Are you aware of any radiation exposures other than X-rays? [ ] No [ ] Yes (describe_____)

Physician Notes (for office use only)

Name_____ DOB _____

Disorders in Your Family

Living	Relationship to You		
* Cystic Fibrosis	[ ] Yes _____	[ ] No	[ ] Don't Know
* Tay-Sachs disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Canavan disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Bloom syndrome	[ ] Yes _____	[ ] No	[ ] Don't Know
* Gaucher disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neimann-Pick disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Fanconi Anemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Familiar Dysautonia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Muscular Dystrophy	[ ] Yes _____	[ ] No	[ ] Don't Know
* Paternal Grandmother	[ ] Yes _____	[ ] No	[ ] Don't Know
* Paternal Grandfather	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neurologic brain/spine	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neural Tube Defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Neural Tube Defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Bone/Skeletal Defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Dwarfism	[ ] Yes _____	[ ] No	[ ] Don't Know
* Developmental Delay	[ ] Yes _____	[ ] No	[ ] Don't Know
* Learning problems	[ ] Yes _____	[ ] No	[ ] Don't Know
* Polycystic kidney disease	[ ] Yes _____	[ ] No	[ ] Don't Know
* Heart defect from birth	[ ] Yes _____	[ ] No	[ ] Don't Know
* Down syndrome	[ ] Yes _____	[ ] No	[ ] Don't Know
* Other chrom. defects	[ ] Yes _____	[ ] No	[ ] Don't Know
* Marfan syndrome	[ ] Yes _____	[ ] No	[ ] Don't Know
* Hemophilia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Sickle Cell Anemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Thalassemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Galactosemia	[ ] Yes _____	[ ] No	[ ] Don't Know
* Deafness/Blindness	[ ] Yes _____	[ ] No	[ ] Don't Know
* Hemochromatosis	[ ] Yes _____	[ ] No	[ ] Don't Know
* None of the above	[ ] Other (specify)_____		

What is your Ancestry?

[ ] African - American
[ ] American. Indian/NativeAmer.
[ ] Ashkenazi Jewish
[ ] Asian-American
[ ] Cajun/French Canadian
[ ] Caucasian
[ ] Eastern European
[ ] Hispanic - American
[ ] Northern European
[ ] Southern European
[ ] Other- (specify)
(_____)

Would you like to be screened for:

[ ] Cystic Fibrosis: __Y__N
[ ] Sickle Cell Anemia: __Y__N
[ ] Tay-Sachs Disease: __Y__N
[ ] Thalasemia: __Y __N

SPOUSE/MALE PARTNER'S SIGNATURE:_____ DATE_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE:_____ DATE_____

Physician Notes (for office use only)